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ABSTRACT

Rapid social change as it affects the mental health of women is examined. Increased stress for women is predicted as social mores change in the future, relaxing sexual relationships toward the fleeting and more casual, and expecting women to attain higher career goals and independence. Projected needs in the field of mental health services are discussed, emphasizing the success of group therapy as a treatment for women who have difficulty coping with life situations. (JD)

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Mental Health Care for Women Students: Year 2000

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MENTAL HEALTH CARE FOR WOMEN STUDENTS: YEAR 2000

Economic analysts forecast that a gallon of milk costing $1.65 in 1978 will cost $6.30 in the year 2000. But the most careful extrapolation cannot describe the women students likely to be seen at a mental health service in the year 2000.

When our technology fails to supply an easy answer, then we must look elsewhere. Attempting to predict what may be appropriate mental health care for women two decades hence, we reviewed consecutive records of 170 women treated in the University of Louisville Student Mental Health Service during the past three years (1975-78). The University of Louisville is an urban, commuter-based, state operated school with a student body of 16,000. Seven thousand of the students are female and 9,000 male but the males who applied to the Student Mental Health Service numbered 50 % of the total.

1. Referral Source. A majority of women applicants were self-referred.
2. Age. Approximately one-third were 17 to 22 years old, one-third were 23 to 26, one-third were 27 to 35. This coincides with governmental estimates that the age 22 years.[1]
3. Academic Status. 100 of the female Mental Health Service recipients were undergraduates, 70 were graduate students.
4. Race. 140 were Caucasian, 18 were Black.
5. SES. The majority occupied low to lower middle socio-economic status.

6. Marital Status. Seventy of the women were single, 50 were married, 50 were divorced, widowed, separated or remarried.

7. Marital Status of Parents. 25% came from divorced homes, more than 75% came from what the women perceived as chronically troubled homes.

8. Types of Problems. Two-thirds presented with a multiplicity of problems concerning all of the following areas:

   (a) unresolved problem relationships with family of origin -- including issues of dependency, acceptance, lack of direct emotional expression.

   (b) current family or other interpersonal relationships--usually a repetition of the unresolved patterns learned in the original family.

   (c) affective disorder: endogenous as well as reactive.

   (d) normative identity conflicts of late adolescence and early adulthood.

   (e) role conflicts: career, marriage, children, a choice of one or the other, or, of more than one, and, if more than one, then, in sequence or simultaneously, or, a rejection of all of these choices.

   (f) consequent inability to function academically, vocationally or socially to some degree.

9. Therapy. Ninety of the 170, had been involved previously in some type of therapy.

One may safely assume that the types of women students' problems will be similar in 2000.

In order to understand, evaluate and plan treatment adequate in both goals and strategies, and not be overwhelmed ourselves, first we must assume the task of delineating the psychodynamic individual problems from the intertwined, socio-cultural factors.

Unless we dare to view these women as whole, multidimensional human beings, equal to but different from men in some aspects, and help them accordingly, we will be just one more cog in their endless and fruitless therapy cycle.

An overriding factor not to be neglected is that one type of female student we may see is different from what might have been labelled as "typical" ten years ago. For example, many such women come from backgrounds which have been more troubled psychologically, supplying support systems for women that have been weak, negative and ambivalent in several vital areas not related to the traditional roles of marriage and motherhood. Thus the woman finds herself primarily in conflict with herself. She discerns her personal values, imbued from childhood, to be in conflict with her newfound intellectual values gleaned from the contemporary socio-cultural and political milieu. If the student is aware of the dichotomy, she has an advantage. Most of the students seen, however, were unaware of this discontinuity of their value system. Their chief complaints, therefore, centered on varied forms of affective distress: depression and its concomitants, anxiety, loneliness of the existential variety, and psychophysiological disorders.

Women's choices of roles have changed, increasing in number and diversity. However, along with this change in choice, there have

come stress and strain and resultant symptoms for some.[2] Many lack the underlying positive self-esteem needed to make a wholesome choice: yet, simultaneously, they feel current cultural pressure and inward obligation to do so. The easy way out of this quagmire in the '50's, was to become pregnant and enter into acceptable motherhood and chauffeurhood; however, now this will not satisfy the woman, nor her marital, school and professional relationships.

A large part of future therapy, consequently, must include educating women to become aware of why they are experiencing conflict, to help them accept the fact that conflict may be useful in stimulating healthy change, and is necessary to some degree for growth to take place. In so doing, we will help them increase their self-esteem, so that then they have the ability to resolve role conflicts and dilemmas by choice rather than by default.

Other characteristics and coping skills which women must develop and exercise are: independence, achievement, authenticity, assertiveness, competitiveness, self-definition, self-determination, self-actualization, self-confidence, and self-knowledge, along with varieties of creativity. They must continue to exercise nurturance, affiliation and femininity , yet be active, flexible and modifiable; the role is truly androgynous, it would seem. They must be aware of and able to express emotions, effectively and at a pace congruent with their lifestyles, so that there will not be the psychological lags that now abound to bring effective functioning close to a halt whenever emotions are unrecognized and unexpressed.

With increase of the foregoing characteristics, women will be able to effect relationships with family, peers and society that are

not based primarily on pleasing another, at prohibitive cost to themselves, but instead will relate to others in a style reflecting the woman's enhanced self-concept.

We note that anxiety, as a negative coping skill, is too all prevading amongst these patients. Their anxiety covers a spectrum from uneasiness to anguish and panic. Superimposed on basic anxiety are current stress and strain. For example, society lauds those women who appear to achieve what most students profess to want; namely, profession, marriage and family, all attained smoothly and successfully, and seemingly without excess effort. In reality, many women simply see themselves as even less capable and become still more anxious. In addition, the lack of current and familiar support systems is enormous, and also increase the level of anxiety. A case in point is quite representative.

Ms. X, a twenty-nine year old, intelligent, white, divorced, Protestant female with one latency aged daughter, was in her senior undergraduate year. She presented herself with chief complaints of: depression, loneliness, alienation, feelings of spiritual isolation, inability to cope. Her problems follow the dissolution of a current heterosexual relationship, the cause of which confused her. She had no supportive systems of interpersonal relations. Her parents lived at some distance; but she had never related well to them and they had their own problems. She had been in the city for several years, but had not developed any close relationships with other women. She was confused about career choice, needed employment, was mildly angry but guilty about the burden of her daughter whom she loved. Ms. X felt she had many unmet needs for emotional and physical intimacy, did not recognize her true feelings, and had never been

able to express emotions (anger, especially) in an acceptable manner. She felt she was the only woman on earth with such seemingly insurmountable difficulties and accepted all the blame for her situation.

This young woman may unfortunately, be typical in the year 2000. Then in her 40's she--or maybe her daughter by then in her mid-twenties--may seek help. Unless we assist the mother now, identify core factors unique to women, and attempt to help her find resolutions, these stumbling blocks will become legacies afflicting future generations and future therapists.

Life in the year 2000 will certainly be an extension of today. Government will be in increasing control of our national lives; the birthrate will be low, divorce and abortion rates will be high; an increasing number of women will be in school and employed in higher status positions. There will be more flexibility for women in work at home and away and they will be increasingly more active in their own behalf. Furthermore, the changing status of the family will go on at an ever increasing pace. If the family becomes more fully child centered and oriented to androgyny rather than gender sterotypes, women, young and old, will experience fewer conflicts, and will learn more adaptive coping skills at an earlier age.

With smaller families, the sibling support system necessarily will shrink and the need for substitute supports will not. With a higher divorce rate, and freer sexual mores, there will be more single women with and without children, more women who have experienced and matured from unsuccessful relationships, more women who have

avoided potentially unsuccessful relationships and remain satisfyingly single, and also more women with chronic lack of self-esteem, who have accepted primary responsibility for the failure of a durable man-woman relationship.

William F. Ogburn's term "cultural lag," aptly describes what we are witnessing, since technology outpaces the human ability to adapt to parallel social and cultural change. (3) This lag appears to be increasing. Alvin Toffler's classic definition of future shock refers to our upset in the face of change and defines for us "a state of shattering stress and disorientation, that we induce in individuals, by subjecting them to too much change in too short a time, and, see consequent: bewilderment, frustration, dizzying disorientation, misreading of reality, breakdown of communication and inability to cope." (4)

In his book Overload, Leopold Bellak outlines the possibility that future generations, in an effort at coping for survival, may move from one relationship to another more readily, and become involved in relationships more superficially, as a response to and defense against the acceleration of change. (5) One might view this projected new era as an extended cocktail party where, superficiality being the rule, long term relationships do not matter and interpersonal commitment is not risked.

Consequent reverberations of dissonance for women will continue to abound in the next decades. Signs and symptoms of depression will become more complex, in keeping with the complexity of life.

For example, the new sexual mores, and modes of satisfaction or dissatisfaction, become perfect grounds upon which to spawn symptoms of underlying depression for women and may add to them.

Among the 170 women seen at the University of Louisville Student Mental Health Service, at least half verbalized problems relating to sexual dissatisfactions. Again, our means of mass communication has spread the hope of superlative sexual satisfactions, again all obtained with seeming ease. Yet these women feel sexual failure. Some enter therapies exclusively for reversal of sexual dysfunction and continue to fail, too often, because the sexual problems at root signified unresolved problems of identity, trust, dependency, depression, unexpressed anger, and so on. Depression also surfaced as dissatisfaction with academic and career choices. In addition, the gamut of psychophysiologic symptoms will expand as our medical knowledge expands but we seem to feel worse as a nation.

Moreover, increasing governmental entry into support for education, through varied grants, including those for rehabilitation, particularly for persons with emotional illness, will enable many more women to step up to, and through, higher education, to gainful employment and personal satisfaction. Nevertheless, we must be aware, that there will be increasing requests for university mental health services which formerly were obtained from communities.

We are fortunate that we work in the student mental health sphere since we tend to use formal diagnosis quite sparingly. We allow the range of the normal adjustment reactions much room for expansion. This allowance is crucially beneficial to women.

What is normative at different ages, and for women coming from different socio-economic, political and cultural backgrounds, is changing and must change, as our awareness and knowledge increase. This is particularly true for the disadvantaged minority groups - the Blacks, Puerto Ricans, Mexican Americans and Native Americans, Appalachian and third world students. The role strains upon them are even greater than on white students.

The therapeutic modality we have used in recent years has met with some degree of success. First, the woman is seen in individual, analytically-oriented psychodynamic psychotherapy, with much active participation by the therapist, in the form of support, empathy, confrontation and teaching of coping skills. At a point when there appears to be growing ego strength, some behavior changes and insight, the student is transferred to group therapy, with the same orientation and goals. These groups consist of undergraduate and graduate women (including medical, dental and law) of ages from late teens to thirties. The support systems they develop, and the mutual learning, through identification, are impressive occurrences. It is amazing to see how quickly they become a cohesive group, one of the classic strengths of womanhood. Thereupon, participants share their formerly unsharable pains: of loneliness, isolation, unresolved mourning of loss of parents, past abortions, fears about femininity and sexuality, depression, dependency, alcohol use, etc. Women's verbal ability seems to gain directness and power from these group experiences, which ofttimes are encouraged continue outside the clinic setting. Pharmacotherapy, couple therapy, and referral of

dependent children, are also available and advocated.

This brief overview of mental health care for women studnets would be incomplete were the therapists not mentioned. Therapists are male preponderantly and, along with the female therapists, they must be involved in personal and private soul-searching review. Therapists have to redefine mental versus social illness and undergo a reorientation and purging of stereotypes, values, attitudes, opinions and feelings about women in general, and particularly about women as students, with future careers, which may include choices similar to our own. Or they may not take our paths.

We, the current and future mental health establishment on campus, shall become less mystified, more aware, more responsive to socio-cultural issues in general as we continue to be part of the informed and empathic support system for women students.

FOOTNOTES

1. Daedalus, Journal of American Academy of Arts & Science; Summer 1967, Vol. 96, No. 3.

2. Moulton, Ruth. "Some Effects of the New Feminism," American Journal of Psychiatry, Vol. 134, No. 1, January 1977.

3. Toffler, Alvin. Future Shock, Random House, Inc., New York: 1970.

4. Ibid.

5. Bellak, Leopold. Overload. New York: Human Sciences Press, 1975.